KS Facility/Provider - Initial and Re-credentialing Application

ATTACHMENTS NEEDED please include with your completed application the following items for each location.

- ☐ W-9 Form completed, signed and dated
- ☐ Copy of current State License/Approval (as applicable)
- ☐ Copy of Medicare/Medicaid Participation Certification (as applicable)
- ☐ Copy of Certifications and/or Accreditation Certificates (e.g. TJC, Medicare, etc.)
- ☐ Copy of CLIA certification (as applicable)
- ☐ Copy of Declaration Sheet and/or Certificate of Insurance
  - o **For HCBS Provider**s who are not providing medical or behavioral health services **General** Liability Insurance Policies
  - o **All other provider types: BOTH** Current **Professional** Malpractice and Comprehensive **General** Liability Insurance Policies

Please note:

- ✓ All applications must complete all questions (unless otherwise noted)
- ✓ Please check the N/A box if not applicable
- ✓ Applications that do not include all requested documents and responses to questions will not be able to be processed.
- ✓ Please return all documents via the method below:
  - **Sunflower**: Robyn Stratton, 534 South Kansas Ave Ste 305, Topeka, KS 66603.
  - **UnitedHealthcare**: Please return this application along with your contract to the address provided on your cover letter or directly to your assigned UnitedHealthcare Contractor.
  - **Amerigroup**:
    - o If FedEx / UPS: Amerigroup, ATTN: Angela Pimentel, 1801 Sara Drive, Ste. H, Chesapeake, VA 23320
    - o If regular mail: Amerigroup, ATTN: Angela Pimentel, PO Box 62509, Virginia Beach, VA 23466

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1. Facility / Provider Name & Address:

Legal Name: _____

DBA Name: _____

Corporate Name (if different): _____

Type of Component (As listed on License or Accreditation):

☐ Ambulatory Surgical Center	☐ Skilled Nursing Facility	☐ Diagnostic Imaging Center	☐ Rehabilitation Facility
☐ Home Health Agency	☐ Hospice	☐ Hospital	☐ Laboratory
☐ FQHC	☐ RHC	☐ Renal Dialysis Center	☐ HCBS
☐ Other _____			

Federal Tax ID Number: _____ Is this Tax ID used for all locations? ☐ Yes ☐ No

*If No, please list on a separate sheet of paper all Tax ID numbers and the Legal Name for each

Primary Address: _____

City _____ County _____

State _____ Zip _____

HANDICAP ACCESSIBLE ADA Compliant	YES YES	NO NO	N/A N/A

Phone (_____) _____ - _____ Ext: _____ Fax: (_____) _____ - _____

Office Hours ☐ Open 24 hours - or complete hours of operations below

MON	TUES	WED	THU	FRI	SAT	SUN

Credentialing Contact / Office Manager _____

Phone (__) ___ - _____ Ext: _____ Fax: (___) ___ - _____

E-Mail Address:

Billing Address: **Same as Primary** ☐ Yes ☐ No **If same as primary, do not complete this section**

Address _____

City ___ State ___ Zip _____

Phone (____) ___ - ___ Ext: ____ Fax: (____) ___ - _

Mailing Address: **Same as Primary** ☐ Yes ☐ No **If same as primary, do not complete this section**

Address _____

City ___ State ___ Zip _____

Phone (____) ___ - ___ Ext: ____ Fax: (____) ___ - _

2. CORPORATE/SYSTEM OWNER (as provided on W-9): ☐ **N/A**

Name: _____
DBA
Name: _____

Address: _____

City ___ State . Zip _____

Phone (____) ___ - ___ Ext: ___ Fax: (___) ___ - ___

3. ADDITIONAL PRACTICE / OFFICE LOCATIONS? ☐ Yes ☐ No **If yes, lease list other practice/office addresses. If additional space is needed, please attach a separate page.**

1

STREET

CITY COUNTY ST ZIP

PHONE FAX

HANDICAP ACCESSIBLE ☐ YES ☐ NO ☐ N/A
ADA COMPLIANT ☐ YES ☐ NO ☐ N/A

Office Hours

☐ Open 24 hours - or complete hours of operations below

MON	TUES	WED	THU	FRI	SAT	SUN

2

STREET

CITY COUNTY ST ZIP

PHONE FAX

HANDICAP ACCESSIBLE ☐ YES ☐ NO ☐ N/A
ADA COMPLIANT ☐ YES ☐ NO ☐ N/A

Office Hours

☐ Open 24 hours - or complete hours of operations below

MON	TUES	WED	THU	FRI	SAT	SUN

3									
	STREET								
	CITY		COUNTY			ST	ZIP		
			Office Hours						
			☐ Open 24 hours - or complete hours of operations below						
	PHONE	FAX	MON	TUES	WED	THU	FRI	SAT	SUN
	HANDICAP ACCESSIBLE	☐ YES ☐ NO ☐ N/A							
	ADA COMPLIANT	☐ YES ☐ NO ☐ N/A							

QUESTIONS #4 & #5 APPLY TO HCBS PROVIDERS ONLY

4. FOR HCBS PROVIDERS: SERVICES Check the services you provide

AUTISM WAIVER

- ☐ AU550 AUTISM SPECIALIST
- ☐ AU554 FAM ADJUSTMENT COUNSELING
- ☐ AU173 INTERPERSONAL COMM.THERAPY
- ☐ AU551 INTENSIVE INDIVIDUAL SUPPORTS
- ☐ AU553 PARENT SUPPORT
- ☐ AU552 RESPITE CARE

FRAIL ELDERLY (FE) WAIVER

- ☐ FE410 ADULT DAY CARE
- ☐ FE441 ASSISTIVE TECHNOLOGY
- ☐ FE510 ATTENDANT CARE SERVICE – PROVIDER DIRECTED LEVEL I
- ☐ FE511 ATTENDANT CARE SERVICE – PROVIDER DIRECTED LEVEL II / III
- ☐ FE518 COMPREHENSIVE SUPPORT – PROVIDER-DIRECTED
- ☐ FE530 FINANCIAL MGMT SERVICE (FMS)
- ☐ FE531 HOME TELEHEALTH-INSTALL/TRAIN
- ☐ FE532 HOME TELEHEALTH-MONTHLY
- ☐ FE509 MEDICATION REMINDER
- ☐ FE515 NURSING EVALUATION VISIT
- ☐ FE252 PERS - INSTALL
- ☐ FE253 PERS – RENTAL
- ☐ FE237 TARGETED CASE MANAGEMENT
- ☐ FE514 WELLNESS MONITORING

SELF DIRECTED SERVICES

- ☐ FE511 ATTENDANT CARE
- ☐ FE518 COMPREHENSIVE SUPPORT
- ☐ FE513 SLEEP CYCLE SUPPORT

PHYSICAL DISABILITY (PD) WAIVER

- ☐ PD500 ASSISTIVE SERVICES
- ☐ PD530 FINANCIAL MGMT SERVICE (FMS)
- ☐ PD535 HOME-DELIVERED MEALS (HDM)
- ☐ PD509 MEDICATION REMINDER SVC
- ☐ PD367 PERS SYSTEM / INSTALL/MONTHLY
- ☐ PDPSA PERSONAL SVC-AGENCY DIRECTED
- ☐ PDSCS SLEEP CYCLE SUPPORT (SCS)
- ☐ PD237 TARGETED CASE MANAGEMENT

SELF DIRECTED SERVICES

- ☐ PDPSS PERSONAL SERVICES
- ☐ PDSCS SLEEP CYCLE SUPPORT

TECHNOLOGY ASSISTED (TA) WAIVER

- ☐ TA530 FINANCIAL MGMT SERVICE (FMS)
- ☐ TA560 HEALTH MAINT. MONITORING
- ☐ TA559 HOME MODIFICATION
- ☐ TA555 INDEPENDENT CASE MANAGEMENT
- ☐ TA561 INTERMITTENT INTENSIVE MED CARE
- ☐ TA557 LONG-TERM COMMUNITY CARE ATTENDANT-AGENCY DIRECTED
- ☐ TA556 SPECIALIZED MEDICAL CARE/RESPITE

SELF DIRECTED SERVICES

- ☐ TA558 LONG-TERM COMMUNITY CARE ATTENDANT

TRAUMATIC BRAIN INJURY (TBI) WAIVER

- ☐ TB503 ASSISTIVE SVCS (Contractors or DME)
- ☐ TB177 BEHAVIOR THERAPY
- ☐ TB178 COGNITIVE THERAPY
- ☐ TB530 FINANCIAL MGMT SERVICE (FMS)
- ☐ TB536 HOME-DELIVERED MEALS
- ☐ TB509 MEDICATION REMINDER SERVICES
- ☐ TB171 OCCUPATIONAL THERAPY
- ☐ TB268 PERS SYSTEM / INSTALL / MONTHLY
- ☐ TB363 PERSONAL SVCS– AGENCY DIRECTED
- ☐ TB170 PHYSICAL THERAPY
- ☐ TB366 SLEEP CYCLE SUPPORT (SCS)
- ☐ TB173 SPEECH/LANGUAGE THERAPY
- ☐ TB540 TRANSITIONAL LIVING SKILLS

SELF DIRECTED SERVICES

- ☐ TB366 SLEEP CYCLE SUPPORT
- ☐ TB363 PERSONAL SERVICES

5. FOR HCBS PROVIDERS - SERVICE COUNTIES Check all counties you will be providing the above checked services
****If you provide different services in different counties, please attach explanation.**

☐ Allen	Coffey	Geary	Johnson	Miami	Pratt	Sherman
☐ Anderson	Comanche	Gove	Kearny	Mitchell	Rawlins	Smith
☐ Atchison	Cowley	Graham	Kingman	Montgomery	Reno	Stafford
☐ Barber	Crawford	Grant	Kiowa	Morris	Republic	Stanton
☐ Barton	Decatur	Gray	Labette	Morton	Rice	Stevens
☐ Bourbon	Dickinson	Greeley	Lane	Nemaha	Riley	Sumner
☐ Brown	Doniphan	Greenwood	Leavenworth	Neosho	Rooks	Thomas
☐ Butler	Douglas	Hamilton	Lincoln	Ness	Rush	Trego
☐ Chase	Edwards	Harper	Linn	Norton	Russell	Wabaunse
☐ Chautauqua	Elk	Harvey	Logan	Osage	Saline	Wallace
☐ Cherokee	Ellis	Haskell	Lyon	Osborne	Scott	Washingtc
☐ Cheyenne	Ellsworth	Hodgeman	Marion	Ottawa	Sedgwick	Wichita
☐ Clark	Finney	Jackson	Marshall	Pawnee	Seward	Wilson
☐ Clay	Ford	Jefferson	McPherson	Phillips	Shawnee	Woodson
☐ Cloud	Franklin	Jewell	Meade	Pottawatomie	Sheridan	Wyandotte

6. LICENSURE/CERTIFICATIONS

Medicare Certified: ☐ **YES** ☐ **NO** (If YES, attach a copy CMS letter indicating Medicare # & effective date)

Medicare Numbers: _____ _____ _____ _____

Medicaid Certified: ☐ **YES** ☐ **NO** (If YES, attach a copy State letter indicating Medicaid # & effective date)

Medicaid Numbers: _____ _____ _____ _____

LICENSE TYPE	STATE	LICENSE #	EXP. DATE

CLIA Number: _____ **Expiration Date:** _____

Other License/Certificate - Type	Number	Expiration Date

7. INSURANCE – Please complete applicable section A or B below:

Professional Liability/Malpractice Liability (Malpractice not required for HCBS providers who are not providing medical or behavioral health services) ☐ No Coverage

Name of Corporate Entity on Declaration Sheet and/or Certificate of Insurance: _____

Name of Carrier	Eff. Date	Exp. Date	Coverage Amount Per Occurrence	Coverage Amount Aggregate	Policy #

Comprehensive General Liability ☐ No Coverage

Name of Carrier	Eff. Date	Exp. Date	Coverage Amount Per Occurrence	Coverage Amount Aggregate	Policy #

QUESTIONNAIRE (*Please answer all questions and provide explanation for affirmative answers.)
Applications that do not include all requested responses and explanations will not be able to be processed.

1. Has the license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed? ☐ YES ☐ NO

2. Has the business been denied participation, suspended from or denied renewal from Medicare or Medicaid? ☐ YES ☐ NO

3. Has business ever had its professional liability coverage cancelled but not renewed? ☐ YES ☐ NO

4. Has the business been denied accreditation by its selected accrediting body (e.g. TJC), or had its accreditation status reduced, suspended, revoked or in any way revised by the accrediting body? ☐ YES ☐ NO ☐ N/A

ACCREDITATION/CERTIFICATION section to be completed by non-HCBS providers only
(Attach a copy of current Accreditation certificate or survey.)

A.

☐ AASM	AAAHC	AAAASF	ABC	ACHC	ACR	AOA	ASDA	BOC Int'l.
CABC	CACH	CAP	CARF	CCAC	CHAP	COA	COLA	CORF
DNV	HCU	HFAP	HQAA	IAC	NABP	NBAOS	TJC	_____

☐ **Other:** _____
☐ **NOT ACCREDITED (complete section B below)**

Date of initial accreditation: _____/_____/_____ Date of next survey_____

Date of last survey: _____/_____/_____

B.

Has provider had an on-site survey by CMS or State agency? ☐ Yes ☐ No Date of last State survey: ____/____/____
If no, successful completion of a health plan onsite visit will be required to complete credentialing. You will be contacted by the Health Plan to schedule the visit.

Non accredited providers must provide a copy of their most recent government agency survey (may not be older than 36 months) along with your Corrective Action Plan (if deficiencies were cited), OR attach letter from government agency stating Facility is in substantial compliance with most recent survey standards. Facilities who don't meet the requirements above require an onsite visit before network status may be granted. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.

Component Attestation/Consent & Release Form

Sunflower State Health Plan

☐ **Decline Sunflower State Health Plan**

I hereby understand that as a prospective/current Sunflower State Health Plan provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to Sunflower State Health Plan Credentials Committee for their review and approval, and, absent such affirmative approval, Sunflower State Health Plan members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from Sunflower State Health Plan. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Sunflower State Health Plan in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Sunflower State Health Plan credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

UnitedHealthcare

☐ **Decline UnitedHealthcare**

ANY ALTERATION OR FAILURE TO SIGN AND DATE THIS FORM WILL RESULT IN THE DELAY OF PROCESSING THIS APPLICATION

By signing below, I attest that I am the duly authorized representative of the Component, that all information on the Application pertains to the above-named Component, and that such information is current, complete and correct.

Your signature is required to complete this application. Stamped signatures are NOT acceptable.

Amerigroup

☐ **Decline Amerigroup**

All information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify Amerigroup of any changes thereto. I understand that this application does not entitle me to participation in Amerigroup. By applying for appointment as an Amerigroup Participating Provider, I authorize the Plan, its medical director and appropriate representatives to consult with administrators and members of other institutions where I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by Amerigroup, its medical director and appropriate representatives of all records and documents, excluding medical records of non-members of Amerigroup's Plans, that may be material to an evaluation of any professional qualifications and competence to carry out the requested duties, as well as my moral and ethical qualifications for Participating Provider status with Amerigroup. I consent and agree that Amerigroup will complete a criminal history background check to determine if I or any Subcontracted Providers have any history of felony convictions, including adjudication withheld on a felony, plea or nolo contendere to a felony or entry into a pretrial for a felony. I agree to obtain any consents or approvals required for my Subcontracted Providers to undergo such background checks. I hereby release Amerigroup and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release any individuals and organizations from any liability that provide information to Amerigroup or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the Ancillary Agreement between me or my group and Amerigroup, as such terms may be applicable to me.

I understand that as an applicant for participation in Amerigroup, I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from Amerigroup, I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the Credentialing Committee, if they so request. I further understand that I may appeal the Committee's decision either in writing or by appearance before the Credentialing Committee, if they so request.

Business Name: _____

Authorized Representative Name
(Print or Type) _____

Title: _____

Signature: _____

Date:

NPI Information as applicable:

NPI Number	Organization / Sub-Part Name	Address	Taxonomy Code	Level Information	NPI Issue Date	If NPI Cancelled, please explain